

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER Rehab Center of Cheraw		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 State Road Cheraw, SC 29520	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46991</p> <p>Based on record review, interviews, and review of the facility policy, the facility failed to ensure 1 out of 3 residents was free from significant medication errors for 1 out of 30 days for the month April 2024. Resident (R)1 received Lyrica; 1 capsule by mouth, 1 time a day and Norco 325 milligrams (mg); 1 tablet, 2 times a day. R1's Controlled Drug Receipt/Record/Disposition Form revealed medication was pulled and reported not administered, which heightened the likelihood of a decline in medical conditions.</p> <p>Findings include:</p> <p>Review of facility's policy titled, Medication Management Program with a revision date of 05/05/23 documented under Administering Medication Pass (8) The authorized staff member or licensed nurse must identify the resident before administering any medication.</p> <p>Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including but not limited to; anxiety, dementia, chronic obstruction pulmonary disease and heart failure.</p> <p>Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 is cognitively intact.</p> <p>Review of R1's Medication Administration History documented the following orders for April 22, 2024: Lyrica 25 mg; 1 time a day (10am) for muscle weakness; Hydrocodone-acetaminophen; twice a day (10:00AM and 9:00PM) for pain.</p> <p>Review of R1's Controlled Drug Receipt/Record/Disposition Form dated 04/08/24 for Pregabalin cap 25 mg, generic for Lyrica, documented on 04/22/24 signature signed off as administered by Registered Nurse (RN)1. Hydrocodone/APAP tab 325 mg generic for Norco, 1 tablet by mouth two times a day as needed for pain signature signed off on 04/22/24, as administered by RN1.</p> <p>Review of RN1's Suspension Pending Investigation dated 04/23/24 documented the suspension of RN1 for the allegation of medication administration errors.</p> <p>Review of RN1's Corrective Action Form dated 05/03/24 documented violation of facility policy action required: termination of RN1.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/03/24 at 11:24 AM in resident's room, R1 stated he remembered when he didn't get his medication. R1 stated the administration of medication on both halls are very strange because he is included on the South Hall, when he resides on the North Hall.</p> <p>In an interview on 06/03/24 at 1:37AM, RN1 stated she was running behind all day, she stated she was new to hall and the halls are split, it's confusing. RN1 stated when she got to R1, he was not in his room, and she thought he wanted dialysis. She stated she was working with a new orientee, and she had checked back several times. RN1 stated when she was asked if R1 received his medications that day, she was honest and stated she hadn't given them to him. RN1 stated she told the truth. RN1 stated she had pulled the narcotic medications, but did not administer them. R1 stated she pulled and wasted the narcotic medications. RN1 stated to dispose, you must have two signatures. RN1 stated she had the new orientee to sign off the medication narcotic sheet witnessing she disposed of the medications. RN1 stated she could not remember the new orientee's name.</p> <p>In an interview on 06/03/24 at 2:28 PM, the Director of Nursing (DON) stated that RN1 stated she disposed of meds. DON stated the disposition of the meds should be listed on the narcotic sheet with two signatures, one as a witness; but this was not done on R1's narcotic sheet. DON stated RN1 admitted to her she did not administer the medications on that day to R1.</p> <p>In an interview on 06/03/24 at 3:16 PM, Administrator stated she expects Nursing staff not to pull medications until the resident is standing in front of them.</p>		